DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2004-017

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932(a)(1)(A) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $(395)
b. FFY 2005 $(1,569)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Attachment 3.1-F, pages 1 through 12~~ See Remarks

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Section 1.6, pages 9c through 9i

10. SUBJECT OF AMENDMENT:
Mandatory Assignment Process for Managed Care Organizations and Primary Care Case Management Programs

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Will forward when received.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Thomas W. Arnold

13. TYPED NAME:
Mr. Thomas W. Arnold

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED:
9/1/04

16. RETURN TO:
Mr. Thomas W. Arnold
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Attention: Kay Newman

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 7, 2004

18. DATE APPROVED:
December 3, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Renard L Murray

21. TYPED NAME:
Renard L. Murray, D.M.

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

Approved with the following change to Item 8 (authorized by the SA on e-mail dtd 11/16/04):

Delete Attachment 3.1-F, pages 1 through 12
Add Section 1.6, pages 9c through 9i

State/Territory: FLORIDA

9c

Citation
Section 1932
BBA 1997

1.6 Managed Care Enrollment

The State of Florida operates under the 1915(b) Medicaid Managed Care waiver, in order to mandatorily enroll Medicaid recipients into managed care. The State will continue to operate mandatory assignment under the authority but will implement lock-in under the provisions of section 1932 of the Social Security Act.

I. Assurances

A. All requirements of sections 1932, 1903(m), and 1905(t) will be met.

B. This option will NOT be used to lock-in the following exempted populations:

(1) Dual Medicare-Medicaid eligibles;
(2) Indians who are members of federally-recognized tribes, and
(3) Children (under 19) who are;

(a) eligible for SSI under Title XIX;
(b) described in section 1902(e)(3) of the Social Security Act;
(c) in foster care or other out-of-home placement;
(d) receiving foster care or adoption assistance; or
(e) receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D)of Title V.

Exempted eligibles will be identified as follows:

(1) Dually enrolled recipients are identified through a buy-in status.
(2) American Indians are identified through the Medicaid eligibility file.

Citation
Section 1932
BBA 1997

(3) Children under the age of 19:
- (a) SSI beneficiaries will be identified through Aid Category.
- (b) Children certified for Medicaid due to institutional deeming are identified through Aid Category.
- (c) Foster Care or other out of home placement will be identified through Aid Category.
- (d) Foster Care or adoption assistance will be identified through Aid Category.
- (e) Title V Children are not identified by aid category, but are identified through participation in the Children's Medical Services Program (CMS).

  If these special needs children are not identified as CMS patients at the time of enrollment, the state will permit their disenrollment upon determination of their CMS eligibility.

C. Individuals will have a choice of at least two managed care entities, managed care organizations (MCOs) under 1903(m)(1)(A), and primary care case management (PCCM) under 1905(t).

The State of Florida contracts with state-licensed, accredited Medicaid HMOs to provide services to

Citation
Section 1932
BBA 1997

Medicaid recipients. The Medicaid Provider Access System (MediPass), is offered to Medicaid recipients as the state's primary care case management program.

In counties where HMOs and MediPass exist, recipients have the choice of any managed care entity. In addition, recipients have a choice of PCPs within MediPass or an HMO. In counties where MediPass is the only managed care entity, recipients have a choice of at least two primary care providers.

D. Beneficiaries will be permitted to disenroll in the first 90 days of enrollment without cause, at any time during lock-in period for cause, and every 12 months thereafter during the open enrollment period without cause. In the last 60 days of the 12-month enrollment period, recipients will be notified that they may request a plan change effective for the next 12-month period. For Medicaid recipients enrolled in managed care plans at, and subsequent to, the implementation of lock-in, membership continues until a request for a plan change is initiated by the recipient. Once a recipient requests a plan change, they will be notified of their right to enroll in another Medicaid managed care option with the mandatory enrollment period and lock-in procedures applied.

State/Territory: FLORIDA

9f

Citation
Section 1932
BBA 1997

E. Medicaid recipients who are subject to mandatory assignment but fail to make a choice shall be automatically enrolled into a Medicaid HMO or to the MediPass program pursuant to the state's 1915(b) Medicaid Managed Care waiver.

F. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, managed care open enrollment (lock-in), grievance and appeal procedures, covered items and services, benefits not covered, cost sharing, and service areas.

Information regarding recipients' rights and responsibilities will be provided by the plan to the recipient through a member handbook. Providers must handle requests to disenroll without regard to that member's health condition or status. Providers will refer all members requesting disenrollment information or assistance to Florida's Medicaid enrollment broker, Florida's choice counseling program, and its toll-free hotline. Florida's Medicaid enrollment broker will initiate choice counseling with each newly eligible recipient by assisting in the initial 30-day decision-making process of a Medicaid managed care entity. Each potential enrollee will have at least 14 days to choose a managed care option. Newly eligible Medicaid recipients are sent choice-counseling materials developed at the fourth grade reading level.

Citation
Section 1932
BBA 1997

These materials include an Area Specific comparison chart which details information on all available managed care entities in the recipient's area, the benefits provided and any cost sharing requirements, the area served, and, if available, quality and performance information. These materials further provide recipients instructions in obtaining telephonic choice counseling. When the member chooses a managed care option or is auto-assigned, Medicaid Options gives notice of the 90 day period to disenroll without cause, after which the recipient shall remain in that managed care option for the remaining nine months of the 12-month period.

In the 60 days prior to the completion of the 12-month period, recipients will be notified that they may request to change managed care entities. These changes would remain in effect for the upcoming 12 month period during which disenrollment would be permitted only for cause.

State/Territory: FLORIDA

9h

Citation
Section 1932
BBA 1997

II. The agency reviews and approves the initial network of all contracted HMOs to ensure that the plan has the capacity to serve expected enrollees; networks of established HMOs are monitored annually. MediPass providers are monitored regularly to ensure that their MediPass caseload does not exceed their approved enrollment cap.

Contract requirements for Medicaid HMOs ensure that primary care providers and hospital services are available within 30 minutes typical travel time, and specialty physicians and ancillary services are available within 60 minutes typical travel time from the member's residence. For rural areas, if the plan is unable to contract with specialty or ancillary providers who are within the typical travel time requirements, the agency may waive, in writing, these requirements. Travel time for MediPass recipients remains comparable to Medicaid fee-for-service.

All managed care options are required to provide access to care 24 hours a day, seven days per week. Through member enrollment materials, recipients receive information explaining how to obtain referrals for specialty care, and how to access 24-hour and emergency care. Additionally, HMO members are provided with a state-administered managed care toll-free hotline number on their HMO membership cards. MediPass recipients may contact Agency area staff with any access issues. The agency monitors both HMOs and MediPass providers to ensure Medicaid recipients have access to covered services.

Citation
Section 1932
BBA 1997

III. All Medicaid managed care organizations will meet the standards of those set in section 1903(m), and all MediPass providers meet criteria for section 1905(t) of the Social Security Act.

(A) The state enters into no capitation contracts for the primary care case management (PCCM) services provided under MediPass. These services are reimbursed on a fee-for-service basis and claims are processed by Medicaid's fiscal agent. Primary care providers are reimbursed a $3.00 monthly administrative fee for each recipient assigned to their caseload.